State of South Dakota

Health Professionals Assistance Program

PARTICIPATION AGREEMENT

I. Identification

Name: **Address:**

Home Telephone:

Primary Profession: **License Number/Student ID Number:**

Worksite: **Address:**

Work Telephone:

II. Standard Conditions

A. I agree to:

1. identify to HPAP a mutually acceptable treatment/continuing care plan and qualified continuing care counselor who will monitor and/or manage all care consistent with my diagnosis. I agree to allow the continuing care counselor and Health Professionals Assistance Program to exchange information related to my recovery**;**
2. meet with continuing care counselor as prescribed in the treatment/continuing care plan. The continuing care counselor will provide, **at a minimum, quarterly reports** regarding treatment/continuing care and progress as related to my recovery**;**
3. meet with HPAP program staff or designee of the program to discuss treatment/continuing care plan **quarterly and/or upon request;**
4. provide to both the continuing care counselor and HPAP the name, address and telephone number of any other providers of care related to my recovery. I also authorize communication between all providers of care and HPAP staff as it relates to recovery or relapse potential; **Must provide a copy of this agreement to all treatment providers -**
5. provide a monthly self-report that describes the previous month's recovery activities, significant events, employment status or work issues and any alcohol or drug use, whether prescribed or over-the-counter. **These reports are to be in the HPAP office by the 7th of each month;**
6. identify a worksite monitor, prior to returning to practice or beginning new employment, including orientation. HPAP must receive confirmation from the employer that they are aware of the individual's participation in the program and of the facility and worksite monitor requirements, including the submission of **quarterly reports** regarding overall work performance**;**
7. inform the program of changes in employment/professional practice site **and** any change of personal address or phone number **within 48 hours;**
8. **pay a fee of $400 per participating year**, and all other costs associated with physical, psychosocial, and other related evaluations, chemical dependency treatments and random drug screens, pursuant to SDCL 36-2A-10; and
9. **NOT COMMIT ANY VIOLATIONS OF LOCAL, STATE, AND FEDERAL LAWS OR RULES GOVERNING THE PRACTICE OF MY PROFESSION IN THIS OR ANY OTHER STATE WHERE PRACTICING.**
10. **NOT PRACTICE IN ANY STATE OR TERRITORY OF THE UNITED STATES EXCEPT SOUTH DAKOTA WITHOUT FIRST OBTAINING WRITTEN CONSENT FROM THE SOUTH DAKOTA LICENSING BOARD, THE SDHPAP, AND THE STATE LICENSING BOARD WHERE I AM REQUESTING TO PRACTICE.**

B. While an active participant in this program:

1. **I AM RESPONSIBLE FOR TIMELY SUBMISSION OF ALL REQUIRED REPORTS; DISREGARD OF THE REPORTING TIME REQUIRMENTS MAY RESULT IN MY BEING DISCHARGED AND REPORTED TO THE BOARD FOR NONCOMPLIANCE.**
2. I may authorize release of information regarding enrollment, Participation Agreement, and monitoring data to any third party. This authorization must be in writing and specify what information is to be provided.

C. If I have been mandated to participate in this program:

1. I understand that the program will submit progress reports to the Board quarterly or upon request.

III. Illness Specific: Conditions/Monitoring Requirements

A. I understand:

1. that I am to **abstain completely from the use of alcohol and other mood-altering chemicals** unless they are lawfully prescribed or managed by a licensed healthcare professional who has been informed of my diagnosis and history. **I agree to report any use of alcohol or non-prescribed mood-altering chemicals immediately to the licensed healthcare provider, HPAP and my treating professional**; and
2. if I am prescribed or dispensed any medication by a licensed healthcare provider, I **agree to cause the licensed healthcare provider prescribing the medication to complete a Medication Report form and return it to HPAP**. The form includes the medication dose, any refills and why it was prescribed. **I will report any prescription for pain, sleep or anxiety medication within in 24 hours of receiving the prescription.**

B. I agree to:

1. refrain from prescribing any drug for myself or a member of my family/household;
2. **respond to random drug screen selection within 8 hours of notification**. I am responsible for all costs associated with collection/testing and understand I will be tested for duration of monitoring. ***There will be a minimum of twelve (12) drug screens during the initial year of monitoring, frequency will be reviewed periodically.***
3. attend a self-help program, such as AA/NA, at a **minimum of two meetings per week,** or more frequently as specified in the continuing care plan developed by the treating professional. I will provide written documentation on a monthly basis regarding attendance;
4. to obtain a Twelve-Step program sponsor within three months of this date, and provide the HPAP with that person's first name and last initial. The sponsor is expected to submit **quarterly** reports as to the my participation in the recovery process;
5. upon completion of treatment and structured aftercare, or upon the treating professional's recommendation, I will attend a professional support group or other professional organization related to recovery **twice a month for a minimum of twenty-four (24) months.** The group facilitator will provide written documentation on a **quarterly** basis regarding my involvement. I will be responsible for all costs associated with professional support group attendance.
6. have no less than monthly contact with a treating professional for the duration of my participation in HPAP.
7. **PRACTICE LIMITATIONS —**

IV. Modifications of Terms

I understand that changes in terms of this agreement may be made by mutual written agreement between the program, and myself but if referred by a participating Board, will never be less than what is established in the Board Order. Such changes will be stated in an addendum to, or revision of, this Participation Agreement.

V. Successful-Discharge

A. This agreement will remain in effect for a period of **FIVE YEARS,** unless the program staff/treating professionals establishes the need in writing for continued limitation and/or continued monitoring of my practice beyond that time.

B. After a minimum term of **FIVE YEARS full compliance and successful completion of conditions,** I may request, in writing, a discharge from the program. The documentation of compliance with all terms and conditions of the agreement will be reviewed.

C. If my participation is required by a Board Order, the agreement will remain in effect for the duration of that Order.

VI. Termination

I understand that failure to comply with the terms of this agreement shall result in referral to the appropriate licensing and/or regulatory Board, consistent with SDCL 36-2A-11, for investigation and possible disciplinary action.

This Participation Agreement signed between SDHPAP and myself is classified as private data, and will be provided directly to me, my continuing care counselor and my worksite monitor. My regulatory/licensing board may have access to this data if the Board referred or mandated my participation or if I am terminated from the program by HPAP. I may provide a copy of this document to any individual directly, but confirmation of compliance, etc., will be provided by the Health Professionals Assistance Program only upon my authorization. It may also be released to any other party to whom I authorize release in writing.

Participant (Print Name)	Signature	Date
	Program Director Signature	Date